Honington Medical Centre

Quality report

Honington
Bury St Edmunds
IP31 1EE

Date of inspection visit:
9 July 2019

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, and information given to us by the practice and patients.

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Chief Inspector's Summary

We previously carried out an announced comprehensive inspection of Honington Medical Centre on 15 May 2018. The practice was rated as requires improvement overall, with a rating of requires improvement for the key questions of safe, effective and well-led. Caring and responsive were rated as good.

We carried out this announced follow-up inspection on 9 July 2019. This report covers our findings in relation to the recommendations made and any additional findings made during the inspection. However, the Primary Care Rehabilitation Facility (PCRF) was not included as part of the inspection due to there being no specialist adviser available.

A copy of the report from the first inspection can be found at:

RAF Honington Medical Centre May 2018 report

At this second inspection, the practice is rated as requires improvement overall.

The key questions are rated as:

Are services safe? – Inadequate
Are services effective? – Good
Are services caring? – Good
Are services responsive? – Good
Are services well-led? – Requires improvement

Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Director Healthcare in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- A small proportion of the practice workload involved chronic disease management and this had improved since our previous inspection.
- A significant backlog of summarising had been cleared and patient notes were being processed in a timely manner.
- The practice had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them.
- The practice fostered an ethos of patient centred care.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice had a better understanding of performance and were better able to review the effectiveness and appropriateness of the care it provided.
- The practice had taken steps to assure itself that care and treatment was delivered according to evidence-based guidelines.

- Patients found the appointment system easy to use. Physiotherapy access targets were being met.
- The programme of quality improvement work had been widened to achieve improved outcomes for patients.
- Communication across the practice had improved with the introduction of a more structured governance framework.

The Chief Inspector recommends:

- Review arrangements for safely managing healthcare waste.
- Risk assess the medicine and equipment requirements needed when dealing with an emergency situation.
- Further strengthen the processes around managing referrals.
- Review systems and processes for medicines management to ensure they are fully effective and being followed.
- Raise staff awareness of translation services available.
- Consider a more proactive approach for the identification of carers.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser, a practice manager adviser and a medicines team inspector.

Background to Honington Medical Centre

RAF Honington Medical Centre is located in Honington near Bury St Edmunds. The treatment facility offers care only to forces personnel. Dependants and children must register at an NHS practice. At the time of inspection, the patient list was approximately 1,400. Occupational health services are also provided to personnel and to reservists.

In addition to routine GP services, the treatment facility offers minor surgical procedures, physiotherapy services and travel advice. Family planning advice is available, with referral onwards to NHS community services. Maternity and midwifery services are provided by NHS practices and community teams.

At the time of our inspection, the facility had a Senior Medical Officer (SMO is a lead GP), two civilian GPs and a locum GP, three practice nurses, a pharmacy technician who worked in the practice dispensary and seven medics (the work of a military medic has greater scope than that of a health care assistant found in NHS GP practices). The facility was led by a warrant officer and a military practice manager, supported by a deputy and a number of administrative staff. The facility was also attached to a primary care rehabilitation service (PCRF) which provided physiotherapy and exercise rehabilitation. The PCRF was led by a physiotherapist and employed a further two physiotherapists and two exercise rehabilitation instructors. A Regional Clinical Director assumes overall accountability for quality of care at the Medical Centre and we interviewed them as part of this inspection.

Are services safe?	Inadequate

We rated the practice as inadequate for providing safe services.

Safety systems and processes

- The practice had safety policies including adult and child safeguarding policies which were reviewed, displayed in clinical rooms and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies accessible to all staff (including locums) outlined clearly who to go to for further guidance.
- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients.
- The practice worked with other agencies to support patients who were trainees and protected them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Practice staff attended meetings with welfare teams and the Chain of Command to discuss the needs of this population group when required.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. A list of trained chaperones was displayed in clinical rooms.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There was an effective system to manage infection prevention and control (IPC) supported by the regional nursing advisor who acted as IPC lead for the practice. The practice IPC link nurse and warrant officer in charge conducted a monthly IPC compliance check of the building. This was recorded on a register together with any follow up action required.
- There were systems for safely managing healthcare waste. However, the clinical waste and pre-acceptance audits were overdue (last completed in May 2018 and April 2018 respectively), the healthcare waste policy was overdue a review from April 2018 and the storage arrangements for waste while awaiting collection were not secured (although the practice told us that the issue had already been reported by the dental centre who shared the storage area). The practice confirmed that a waste management audit was completed after the inspection.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. The safety certificates for water, gas, electric and legionella were held by the unit and not available on the inspection day. However, the practice sent evidence that all certificates were valid post inspection.

Risks to patients

There was a system to assess, monitor and manage risks to patient safety. However, we found some gaps.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods. There was a short-term manning issue within the PCRF,

a locum physiotherapist was due to start and patients continued to be seen within the DPHC target of 10 days.

- There was an induction system in place for temporary staff and this had been tailored to their role.
- Clinicians adhered to military guidance around sickness periods for personnel. They communicated effectively with Chain of Command so that line managers knew which tasks personnel could safely undertake.
- The practice was mostly equipped to deal with medical emergencies although there was scope for additional training in the understanding of emergency procedures by reception staff. There had been no risk assessment of which emergency medicines should be routinely available and there was some medicines missing for the urgent treatment of meningitis. Following the inspection, the practice confirmed that they had reviewed the emergency medicines held and added an addition item to the crash trolley.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff, the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

At our previous inspection we identified that staff did not always have the information they needed to deliver safe care and treatment to patients because individual care records were not always written and managed in a way that kept patients safe. The system to manage hospital letters was not failsafe and there was a backlog in electronic summarising. Since May 2018, the practice had worked hard to make improvements.

- The system to manage pathology results was effective. There was a responsible individual and several staff members were trained to cover any period of absence.
- The practice had cleared the significant backlog in electronic summarising and there was only 31 sets of notes awaiting summarisation (summarising was a significant issue at the last inspection when the practice highlighted a backlog of approximately 1,200 patients).
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results with named staff responsible.
- Referrals and hospital appointments were managed by the administrative team and patients were well supported to obtain the timeliest access to secondary care. A standard referral template letter was in use by clinicians and an audit had been done to ensure that referrals were being written in the most effective way. However internal referrals (to other healthcare services within the military) had not been included and the tracking of referrals could be improved.
- Staff told us that access to clinical records in the clinical system (known as DMICP) was generally reliable but sometimes delayed due to connection issues. In such an event, regional headquarters was informed and a tannoy announcement informed patients that only urgent appointments could be facilitated. Clinic appointments, printed on the day preceding, made practice staff aware of who is due in for an appointment so they could ensure patients were contacted and appointments rearranged. This was included in the practice business continuity plan.

Safe and appropriate use of medicines

Although we found improvements in areas highlighted at our last inspection, the practice's systems for appropriate and safe handling of medicines required further strengthening:

- There were gaps in the systems for managing and storing medicines, including vaccines, and emergency medicines and equipment. We found that checks carried out were not identifying all items that had exceeded the expiry date and data loggers (used for monitoring fridge temperatures) had not been used effectively. Following the inspection, the practice confirmed that medicine that had exceeded its expiry date had been disposed of.
- The practice's arrangements for the access, storage and monitoring of prescription stationary required review. The practice confirmed that after the inspection, a date column had been added to the prescription record.
- The practice routinely held controlled drugs on the premises. Storage and access arrangements were satisfactory but there were gaps in the monitoring of items prescribed.
- The policy for access to the dispensary in the absence of the pharmacy manager was not always followed. Staff told us that access was not always logged. Following the inspection, the practice introduced a tamper-proof serial-numbered bag used for the dispensary key.
- Written procedures (SOPs) were in place to support safe dispensing practice. However, we found that GPs, nurses and medics had not signed some SOPs applicable to them; for example, temperature monitoring and controlled drugs checks, and some processes detailed in an SOP were not being followed. There was no system to monitor compliance with the SOPs.
- Staff had access to British National Formulary (BNF) and prescribing formulary. An antibiotic prescribing audit update had been undertaken since the last inspection to ensure that prescribing practice was in line with local guidelines. We saw recent input from a regional pharmacist in terms of prescribing and dispensing support and oversight.
- Prescriptions were signed before medicines were dispensed and handed out to patients.
- The management of repeat prescriptions had been reviewed to ensure that patients taking high risk drugs had the relevant monitoring checks before their repeat prescription was issued.
- PGDs (Patient Group Directions) and PSDs (Patient Specific Directions) were in use to allow non-prescribing staff to carry out vaccinations in a safe way. PGDs were appropriately managed as staff had received training and authorisation by the SMO had been recorded. Authorisation for PSDs was now in line with DPHC PSD policy and the form ensured patient confidentiality was maintained. There was scope to improve the management of PSDs through audit. After the inspection, the practice told us that an audit of PSDs had been introduced and would be repeated six monthly.

Track record on safety

The practice had a good safety record:

- The warrant officer in charge was the lead for health and safety and was deputised by the practice manager. Risk assessments in place included needle stick injury, lifting and handling, legionella management and lone working.
- The new facilities that housed the medical centre had an inbuilt alarm system in all clinical areas that was audible throughout the building.

- A risk register was kept and reviewed monthly. In addition, a separate record of short-term issues was logged.

Lessons learned and improvements made

The practice shared learning and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. There was evidence that the practice learned and shared lessons, identified themes and took action to improve safety in the practice. Staff we spoke with could recall the learning from some recent significant events and minutes of meetings showed lessons learnt were discussed at the practice meeting.
- There was a system for receiving and acting on patient safety alerts and the pharmacy manager was the responsible individual for managing alerts. Central Alerting System (CAS) alerts were forwarded to clinicians for their review and any action taken was documented. There was a dedicated member of staff responsible for managing device alerts. However, we found that a search for patients on a medicine that can cause complications in pregnancy had not been run since May 2018 and terms of reference (TORs) required updating to reflect the responsibility by individual.

Are services effective? | Good

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Clinicians were aware of relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. At our last inspection we saw instances where these were not being followed to deliver care and treatment that met patients' needs, specifically the management of long-term conditions. At this second inspection, work was ongoing to ensure that best practice guidelines were being followed. Clinical meetings had been held and minutes contained a record of discussion of best practice guidance.

- Our review of patients' notes showed that NICE best practice guidelines were being followed.
- Staff we spoke with could refer to this and gave examples of updates they had acted on and discussed within the practice.
- The Defence Primary Health Care (DPHC) Team produced a newsletter that was circulated to clinicians providing further information and a summary of relevant safety updates.

Monitoring care and treatment

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The Defence Medical Services (DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS). Because the numbers of patients with long-term conditions are often significantly lower at DPHC practices, we are not using NHS data as a comparator.

The practice provided the following patient outcomes data to us from their computer system on the day of the inspection:

- There were three patients on the diabetic register. We reviewed the treatment and care offered to these patients and found that current NICE guidance had been followed. For one of these diabetic patients, the last measured total cholesterol was 5mmol/l or less which is an indicator of positive cholesterol control. All three patients had had a diabetic review in the preceding 12 months.
- There were 12 patients recorded as having high blood pressure and all patients had been reviewed and a record for their blood pressure taken in the past nine months. Six of these patients had a blood pressure reading of 150/90 or more (the level for mild hypertension). At the previous inspection we found that NICE guidance had not always been followed. We reviewed the treatment and care offered to these patients and found that treatment was now being given in line with national guidelines.
- There were 22 patients with a diagnosis of asthma. Following our initial inspection, the practice had improved the number of patients where smoking status had been recorded and patients' notes included when smoking cessation advice had been offered to asthmatics. 67% of asthmatics had had an asthma review in the preceding 12 months which included an assessment of asthma control using the three RCP (Royal College of Physicians) questions.
- At our previous inspection, due to the number of different Read codes in use, the practice could not easily provide information about patients with a new diagnosis of depression. At this inspection we found eight patients had been identified as having depression, all were appropriately Read coded and an alert on the clinical system (DMICP) highlighted these patients as vulnerable.
- Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Data from July 2019 showed that 94% of patients' audiometric assessments were in date (within the last two years). DPHC do not have comparative local or national data.
- The medical centre had undertaken additional quality improvement work, including clinical audit, and there were signs that this was beginning to deliver improved outcomes for patients. A structured programme of clinical audit work had been established and commenced since our last inspection, including audits of asthmatic patients, patients with depression, minor surgery and antibiotic prescribing. These clinical audits were relevant to the practice population and we saw evidence that they had triggered improvements in outcomes for patients.
- An internal quality assurance tool, the Defence Medical Services (DMS) Common Assurance Framework (CAF) was used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained.

- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, mentoring, clinical supervision and support for revalidation. The induction process had a separate annex for each professional cadre with an additional reference manual for GPs.
- The nursing department's staffing levels had improved. A new nurse had been appointed but was new to primary healthcare and as yet had received no specific mentorship. Nursing staff held informal meetings that were not minuted. However, the regional nursing lead was working on a set of initiatives to improve the support for nursing staff. These included:
    - The development of a nurse specific induction pack
    - A training pathway for the professional development of nursing staff (as part of a programme being developed by DPHC)
    - Formal clinical supervision, peer review and mentorship for nurses.
    - A standardised template for disease management.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

Staff worked together and with other care professionals to deliver effective care and treatment. The practice met with welfare teams and line managers to discuss vulnerable patients who were both trainees and permanent staff.

- The warrant officer attended local NHS meetings and received regular updates that were shared with colleagues. There was scope to further develop further links with military practices to improve the handover of patients.
- The healthcare assistant had developed links with the Terrence Higgins Trust, a charity that provides services relating to HIV and sexual health.
- The Medical Centre is located within the same building as the PCRF service which provides physiotherapy assessment and treatment and an exercise rehabilitation service. Referral into the service is via a primary care clinician. Patients were able to obtain swift access to the PCRF and strong partnership working arrangements resulted in co-ordinated and person-centred care for patients.
- The SMO had a specialist interest in dermatology and reviewed cases from other military bases and had participated in clinics in the local hospital.

Helping patients to live healthier lives

The practice identified patients who may need extra support and signposted them to relevant services. For example:

- Patients at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.
- The practice offered basic sexual health advice including the issue of free condoms and referred on to local clinics in the community for more comprehensive services including family planning.
- Medical centre staff attended unit open days and manned stalls to provide health promotion information to personnel. Notice boards were used in the waiting area for health promotion campaigns.

- Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50 to 64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs.
- The number of women aged 25 to 49 (there were no women patients aged 50 to 64) whose notes recorded that a cervical smear had been performed in the last three to five years was 97 out of 125 eligible women. This represented an achievement of 78%. The NHS target was 80%. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using public health information posters and they ensured a female sample taker was always available.

It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. The data below from July 2019 provides vaccination data for patients using this practice (regional and national comparisons were not available):

- 90% of patients were recorded as being up to date with vaccination against diphtheria.
- 90% of patients were recorded as being up to date with vaccination against polio.
- 95% of patients were recorded as being up to date with vaccination against Hepatitis B.
- 96% of patients were recorded as being up to date with vaccination against Hepatitis A.

90% of patients were recorded as being up to date with vaccination against Tetanus.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance. For example, verbal consent was recorded in DMICP and PCRF staff took written consent for acupuncture procedures.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

When providing care and treatment for young recruits aged between 16 and18 years, staff carried out assessments of capacity to consent in line with relevant guidance.

Are services caring?	**Good**

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The medical centre had taken account of patients' personal, cultural, social and religious needs; for example, translation services were available.
- The practice gave patients timely support and information.

- A notice on the reception desk informed patients that if they wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We received 39 patient Care Quality Commission comment cards in total. Of these, 27 were entirely positive about the service experienced, 11 were mixed and one was negative. Patients praised the helpfulness of the medical centre staff and felt that a good service was being provided in particular by the PCRF. Mixed comments contained a theme of wait times for routine medicals. One patient had overheard discussion about their appointment request.
- The practice had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

Involvement in decisions about care and treatment

- The clinicians and staff at the practice demonstrated that they recognised that the trainee personnel they provided care and treatment for, could be making decisions about treatment for the first time. Staff demonstrated how they gauged the level of understanding of patients, avoided overly technical explanations of diagnoses and treatment, and encouraged and empowered young patients to make decisions based on sound guidance and clinical facts.
- Interpretation services were available for patients who did not have English as a first language. However, staff were not always aware of the 'big word' translation service provided to all DPHC practices. Staff told us that patients who required translation were usually accompanied by a friend or relative.
- The Choose and Book service had been implemented and was used to support patient choice as appropriate. (Choose and Book is a national electronic referral service which gives patients the choice of date and time for their first outpatient appointment in a hospital).
- Results from the practice's Patient Experience Survey in December 2018 (31 responses were collated,
    - 90% said they felt included (10% gave a 'not applicable' response) when asked if they felt included in their treatment and care.
    - 95% of patients who responded said that their privacy and dignity were respected.

The data presented by the practice was not benchmarked against regional and national averages for DMS, or against the previous year's performance.

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of organisations. We saw information that was age appropriate and relevant to the patient demographic which was prominently displayed and accessible. For example, we saw dedicated notice boards to promote 'Headspace' a scheme launched to support mental health wellbeing of RAF personnel.
- The practice acted in a compassionate way toward any patient that had to be discharged on health grounds. We saw that the practice reassured these patients and signposted to personnel within the military who could guide them through the exit process and transition to NHS care and other support functions.
- Practice staff told us that the station welfare staff kept a register of patients who were also carers and provided extra support as required. The register was blank as no carers had been identified to date.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice had identified the fact that conversations with receptionists could be overheard by patients in the waiting room, due to the open plan nature of the waiting area. The seating was set back from the reception desk, signage asked patients to stand back while waiting to be seen and music and television had been provided to assist with privacy.

Are services responsive to people's needs?	Good

We rated the practice as good for providing responsive services

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, twice daily sick parade, access to telephone consultations and quick access to physiotherapy and exercise rehabilitation. Furthermore, we saw examples of the medical centre proactively finding ways to meet the health and wellbeing needs of certain patient groups by utilisation of the waiting area for health promotion.
- The facilities and premises were bespoke and appropriate for the services delivered. An access audit had been completed in June 2019 and resultant action (two patient signs) completed.
- At our previous inspection, the practice did not have a policy available to staff or patients around when a home visit might be necessary and appropriate. A policy had been implemented and was included in the practice leaflet.
- The practice trained staff in equality and diversity and there was a 'diversity and inclusion' lead.

Timely access to care and treatment

- Routine appointments are usually available within a few days. We checked on the day of our inspection and the next available routine appointment was the following day. Urgent appointments are available on the same day.
- Outside of routine clinic hours, telephone cover was provided by a GP. From 18.30 hours, patients were diverted to the NHS 111 service. If the practice closed for an afternoon for training purposes, patients could still access a GP in an emergency. In this way, the practice ensured that patients could directly access a GP between the hours of 08.00 and 18.30, in line with DPHC's arrangement with NHS England.
- The nearest accident and emergency department was located at the West Suffolk Hospital in Bury St Edmunds (approximately 13 miles away). The practice leaflet did not include clear directions on local accident and emergency unit access although this was added after it had been highlighted.
- The Defence Rehabilitation Headquarters collates a dashboard of information in relation to waiting times and patients who do not attend for their appointment. These are key

performance indicators as timely access to physiotherapy and rehabilitation are important for effective patient recovery. However, the dashboard was not available when we inspected as it was being updated nationally. We noted that urgent appointments had been made available for patients that needed them. Access to physiotherapy was significantly quicker (under 10 days) than equivalent NHS services.

- Results from the practice's patient experience survey (31 responses were received) showed that patient satisfaction levels with access to routine care and treatment were high;
    - 91% of patients said they felt their appointment was at a convenient time.
    - 97% of patients felt their appointment was at a convenient location.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Defence Primary Health Care had an established policy and the practice adhered to this.
- The warrant officer in charge was the designated responsible person who handled all complaints in the practice.
- We reviewed complaints that had been submitted by patients in the past 12 months. We saw that there were processes in place to share learning from complaints. Complaints management was comprehensive and included an audit to identify any trends. The last audit (July 2019) showed no obvious trend but highlighted a reduction in the number of complaints received.
- We saw that information was available to help patients understand the complaints system.

Are services well-led?	Requires improvement

We rated the practice as requires improvement for providing a well-led service.

Leadership capacity and capability

The leaders at the medical centre had been working hard to address areas they had identified as requiring improvement. Significant work had been undertaken to ensure that care for patients had improved since our last inspection at Honington Medical Centre although progress in some areas had been restricted due to gaps in manning.

- Staff felt that they could raise concerns if they had them. A practice-wide meeting had been established where all staff could get together to share and learn from key messages. Regular social events held helped develop a team approach.
- The practice was well supported by the regional management team and in particular, the regional team supported new initiatives for the nurses that included formal supervision and clinical support.
- Leaders were knowledgeable about issues and priorities relating to the quality of services. As a result, key risks were being addressed.
- There was flexibility within leadership roles to ensure continuity in each department.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- The practice had formulated their own mission statement developed through engagement with the station: 'To maintain the health and operational effectiveness of RAF Honington through efficient and high-quality healthcare' and there was a drive to become an exemplar standard for the region now that the long-term future of the base had now been confirmed and manning levels had been addressed.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The medical centre planned its services to meet the needs of the practice population.

Culture

The practice had a culture of high-quality sustainable care and key systems had been reviewed to make them more effective:

- Staff stated they felt respected, supported and valued. Discussion with staff members indicated that morale had improved since the last inspection.
- The practice focused on the needs of patients.
- Leaders and managers had taken action to address gaps in the performance of the practice, specifically the establishment of a programme of clinical improvement work and the timely summarisation of patient notes.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. Opportunities for staff to have positive influence on the practice had been extended due to the establishment of a regular practice wide forum.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received annual appraisals and were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. We noted that medics were well trained, supported to deliver their roles and had specific areas of responsibility.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training.
- There were positive relationships between staff and teams.

Governance arrangements

Having filled the majority of gapped posts, the practice had consolidated and clarified responsibilities, roles and systems of accountability to support good governance and management. Improvements had been made since the last inspection, however further strengthening was required in some areas:

- Joint working with the welfare team, pastoral support and Chain of Command was in place with a view to safeguarding vulnerable personnel and ensuring co-ordinated person-centred care for these individuals. The Department of Community Mental Health (DCMH) provided a weekly

outreach service at the practice which fostered strong links between the practice and the department.

- The PCRF delivers rehabilitation services from the same building as the medical centre. The service enables patients to access timely, holistic care. Staff working within the PCRF felt integrated within the medical centre team.
- Shared care protocols were now in place for patients taking high risk drugs and an effective recall system implemented for the effective management of patients with a long-term condition.
- Practice leaders had established a number of policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However, this did not always apply to those policies for medicines management and clinical waste. Some SOPs required review or updating.
- An extensive meeting schedule was established. This included healthcare governance, clinical development, full practice meeting and management meetings held monthly. Junior rank meetings were held every six weeks and heads of department meetings held every two months. Discussion at each meeting was recorded and made available to those unable to attend.
- A programme of clinical improvement work was being implemented and was starting to drive improvements in patient outcomes.

Managing risks, issues and performance

There were some clear and effective processes for managing risks, issues and performance. However, there was scope to strengthen the medicines management systems and processes and the referral tracking system.

- Following our initial inspection, practice leaders had established a governance structure that provided oversight of risk and the quality of service.
- The practice maintained a risk register a record of short-term issues. We saw that these were reviewed regularly and acted on.
- Clinical audit was having an impact on quality of care and outcomes for patients. We were shown clear evidence of action to change practice and improve quality.
- The practice had written and implemented an SOP for the deactivation of IT accounts as soon as staff ceased working within the practice to prevent any data breach.
- There was a business resilience plan and a station major incident plan that were reviewed regularly and tested through simulation.

Appropriate and accurate information

- An understanding of the performance of the practice was maintained. The warrant officer used the Common Assessment Framework (CAF) as an effective governance tool. A number of different meetings were held regularly and extended to the whole team. A practice wide meeting had been established and had provided a forum for effective discussion and shared learning. Minutes from meetings we reviewed demonstrated that key agenda items had been discussed including safeguarding, NICE guidance and CAS alerts. Meetings were used for forward planning, for example, to ensure that patient needs were met during busy clinic times and periods of staff sickness.
- At our previous inspection we identified that information used to monitor performance and the delivery of quality care was not always accurate and useful. Since then, staff had worked to ensure that Read coding for specific patient cohorts was applied more consistently. Where

Read coding remained an issue, clinicians had reviewed the care given to individual patients to ensure that it was in line with national guidelines. Staff had agreed to use consistent clinical templates to ensure more standardised delivery of care for patients.

- Since the last inspection, the practice had improved the management of hospital letters and the record keeping relating to treatment plans.
- There were robust arrangements at the medical centre in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. This extended to the PCRF.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- We saw examples of the practice focussing on continuous learning and improvement. For example, the practice had experienced long delays getting IT accounts and password resets via the station. This resulted in the delayed induction for locum staff so the practice had trained a member of staff to be able to perform these duties.
- The practice nurse promoted better sexual health with the introduction of a ‘C’ card (condom card, a scheme that allowed patients to obtain free condoms) and planned future clinics for immediate chlamydia/sexually transmitted infections testing.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Nursing staff were part of a supportive interregional network which facilitated clinical supervision and ideas sharing.